tion whether all patients with falciparum malaria who have travelled in vivax-endemic areas should not also receive a course of primaquine prophylaxis. The cases should also remind physicians to consider vivax malaria as a cause of febrile illness in a traveller who has been out of the tropics for up to 3 years.

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Recognizing your limitations

I compliment Dr. Eileen Murray for her very sensitive remarks concerning the ethics of commenting on other physicians' treatments (*Can Med Assoc J* 1989; 140: 1131–1132).

I have always felt that it is so easy to inadvertently induce in a patient's mind the idea that another physician's treatment is less than optimal and so create unnecessarily a potential lawsuit scenario. I am sure that we all have come across situations in which treatment received from another physician, as related by the patient, seems to be not what we would prescribe, but I try very hard to ensure that my comments are not construed as open criticism of the other physician, and I hope that other doctors would treat me likewise.

We must realize that medicine is seldom the practice of "black and white" but is many shades of grey. If we feel that a treatment may be obsolete, superseded or outdated, surely our professional and ethical responsibility is to contact the physician concerned and discuss it with him or her directly.

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Premenstrual syndrome

The current popularity of self-diagnoses — premenstrual syndrome (PMS) and "chronic fatigue syndrome" — reflects a conspiracy against reality in today's narcissistic and hedonistic society.

A recent article in the *International Drug Therapy Newsletter*[1] indicates that alprazolam, which appears to ameliorate the symptoms of PMS,[2,3] is the only benzodiazepine that has a distinct antidepressant effect in addition to its anxiolytic and sedative effects. This finding may lend support to my clinical impression that many women who do not meet the diagnostic criteria for premenstrual syndrome may have primary depression with accompanying anxiety.

It is important to diagnose psychiatric conditions by their own criteria and not merely by the exclusion of medical conditions.

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Guidelines for the use of intravenous thrombolytic agents in acute myocardial infarction [correction]

In this article (*Can Med Assoc J* 1989; 140: 1289–1299), by Drs. C. David Naylor and Paul W. Armstrong for the Ontario Medical Association Consensus Group on Thrombolytic Therapy, the first sentence in the "Comments" section on page 1296 should have read as follows: "In summary, the key advantages of tPA appear to be higher recanalization rates . . . and a reduced risk of allergic side effects, which are, however, likely to lead to anaphylactic shock in no more than 1 of every 1000 [rather than 100] people treated with streptokinase . . .". — Ed.

Management of acute asthma [correction]

In this letter (*Can Med Assoc J* 1989; 140: 1127–1128), from Drs. J. Mark Fitzgerald and Frederick E. Hargreave, the second-last sentence should have begun as follows (added information is in italics): "A prospective evaluation of outcome of our emergency department management of asthma *(unpublished data), described in a recent review article,*[5] showed . . .". The results of the prospective evaluation have been submitted for publication. — Ed.